PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICE	S
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303			ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED	
			A. BUI B. WIN			05/09/2	
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			800 E C	OHIO ST			
GOOD S	AMARITAN SOCIET	TY SHAKAMAK RETIREMENT CO	MMC	JASON	IVILLE, IN47438		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K0000	REGULATORT OR	ESC IDENTIFTING INFORMATION)	+	IAG			DATE
KUUUU							
	A Life Safety Co	ode Recertification	K	0000			i
	and State Licen	sure Survey was					
	conducted by tl	he Indiana State					
	Department of	Health in					
	accordance witl	h 42 CFR 483.70(a).					
	Survey Date: 0	5/09/11					
	Facility Number	r: 000200					
	Provider Numbe	er: 155303					
	AIM Number: 1	00367980					
	C	Durahaan Lifa Cafata					
	Surveyor: Lex Brashear, Life Safety  Code Specialist						
	Code Specialist						
	At this Life Safe	ety Code survey,					
	Good Samaritar	n Society Shakamak					
	Retirement Con	nmunity was found					
	in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR						
	Subpart 483.70	•					
		he 2000 edition of					
	the National Fir						
		PA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.						
	This one story	facility was					
	•	be of Type V (111)					
		,, , ,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U57U21

Facility ID:

000200

TITLE

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155303		155303	(X2) MU A. BUIL B. WING	DING	NSTRUCTION  01	(X3) DATE S COMPL 05/09/2	ETED
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	alarm system we detection in the spaces open to facility has a call had a census of this survey.  Quality Review by Its Safety Code Special 05/09/11.  The facility was substantial confacorementioned.	ne facility has a fire with smoke e corridors and the corridors. The apacity of 75 and f 54 at the time of Robert Booher, REHS, Life ist-Medical Surveyor on a found in appliance with the					
K0050 SS=C	varying conditions shift. The staff is to is aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement manualible alarms.  Based on recordinterview, the formsure fire drill varied times for	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 d review and acility failed to	Κ0	050	Survey Event: ID U57U11 Survey Date: 5/09/11		05/11/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

U57U21 Facility ID:

000200

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
<b>I</b> 155303	B. WING		05/09/2011	
		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER	l l	OHIO ST		
GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT CO		IVILLE, IN47438		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG: PECULIATORY OR LSG IDENTIFYING INFORMATIONS	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
deficient practice could affect all		K050 NFPA 101 LIFE SAFET CODE STANDARD	Y	
residents in the facility.		CODE STANDARD		
		Fire drills are held at unexpected	d	
Findings include:		times under varying conditions, at		
		least quarterly on each shift. T	I	
Deced on wellow of the Coeffe to		staff is familiar with procedure	I	
Based on review of the facility's		is aware that drills are part of		
fire drills since April of 2010 in		established routine. Responsib	ility	
the Fire and Safety Report Manual		for planning and conducting dr	· I	
on 05/09/11 at 9:10 a.m. with the		assigned only to competent per	I	
Maintenance Supervisor present,		who are qualified to exercise		
three of four first shift fire drills		leadership. Where drills are		
		conducted between 9PM and 6.		
were held between 9:53 a.m. and		coded announcement may be us	l l	
10:58 a.m., four of four second		instead of audible alarms. 19.7	.1.2	
shift fire drills were held between				
2:27 p.m. and 3:57 p.m., and four		This STANDARD is not met as	I	
of four third shift fire drills were		evidenced by: Based on review	l l	
		interview, the facility failed to		
held between 2:00 a.m. and 2:45		fire drills were held at varied ti	I	
a.m. During an interview at the		for 3 of 3 employee shifts during		
time of record review, the		4 quarters. This deficient pract could affect all residents in the	ice	
Maintenance Supervisor		facility.		
acknowledged the times of all		lacility.		
three shifts fire drills.		1. No residents were found to h	ave	
direc simes me arms.		been affected by the deficient	""	
2.1.10(1)		practice.		
3-1.19(b)		<b>_</b>		
		2. All residents would be identi	fied	
		as being affected by the deficie	nt	
		practice had it continued. No re	sident	
		was affected. CORRECTIVE		
		ACTION: Fire drills will be h		
		unexpected times under varying		
		conditions at least quarterly on	each	
		shift.		
		2 All Graces 31 6		
		3. All Staff responsible for		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	A. BU	ILDING	NSTRUCTION  01	(X3) DATE COMP 05/09/	LETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE OHIO ST VILLE, IN47438		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE OPRIATE	(X5) COMPLETION DATE
					implementing a fire drill was erviced by the Administration the regulations and require the fire drill.	itor as to	
					<ul> <li>4. The scheduled fire drill monitored by the Mainten Director and the Quality A Director to ensure they are unexpected times under vaconditions, at least quarter shift.</li> <li>5. Completion Date: 5/11</li> </ul>	ance ssurance held at arying ly on each	